Dr. Wright's Vision Source Patient Form

Personal Information

Patient's First, MI, Last_____

Patient's Mailing Address_____City, State, Zip _____

Patient's Phone Number, Type _____ Patient's Email _____

Preferred Contact Method *Home Phone / Cell Phone / Email / Text / Other (please explain)*_____

Patient's Date of Birth _____ *Male / Female* Patient's Social Security Number _____

Patient's Language, Race, Ethnicity _____Patient's Employer_____

Patient's Marital Status *Married / Single / Divorced / Widowed*

Whose name would you like your family account to be under? (Head of Household)_____

If the patient is not the Head of Household, please fill out the following information.

Head of Household Employer _____Head of Household Social Security Number_____

Head of Household Date of Birth_____ Head of Household Relationship to Patient_____

If your spouse is not your Head of Household, please fill out the following information.

Spouse's Name _____Spouse's Date of Birth _____Spouse's Employer _____

General Information

Name of Family Physician _____ Pharmacy You Use _____

Please circle Yes or No. Technician will ask you to explain further once in exam room.

General health problems? *Yes / No* Eye health problems? *Yes / No* Family history of eye disease? *Yes / No*

Taking any medication or vitamins? *Yes / No* Allergic to any medications? *Yes / No*

Trouble seeing while driving at night? *Yes / No* Does glare bother you while driving at night? *Yes / No*

How many hours in a day do you spend outside or daytime driving?_____

How many hours in a day do you spend on a computer, tablet, or electronic device?_____

Do you currently wear contact lenses? *Yes / No* If not, are you interested in contact lenses? *Yes / No*

Is there anything you would change about your current glasses or contact lenses? *Yes / No*

What are your main hobbies?_____Grade in School_____

Payment is expected when services are rendered. Please